Department of Mental Health

TRANSMITTAL LETTER

SUBJECT **Continuity of Care**		
POLICY NUMBER	**DATE**	**TL#**
DMH Policy 200.2	July 25, 2002	14

Purpose. To establish specific guidelines to ensure continuity of care between core services agencies (CSAs) and all other providers of mental health services and supports to Department of Mental Health (DMH) consumers.

Applicability. Applies to D.C. Community Services Agency (D.C. CSA), St. Elizabeths Hospital (SEH), private core services agencies (CSAs), subproviders, specialty providers, private hospitals, contractors, and the Mental Health Authority; and all other providers who have an agreement or contract with DMH or certified providers regarding provision of services.

Policy Clearance. Reviewed by affected responsible staff and cleared through appropriate MHA offices.

Implementation Plans. A plan of action to implement or adhere to a policy must be developed by designated responsible staff. If materials and/or training are required to implement the policy, these requirements must be part of the action plan. Specific staff should be designated to carry out the implementation and program managers are responsible to follow through to ensure compliance. Action plans and completion dates should be sent to the appropriate authority. Contracting Officer Technical Representatives (COTRs) must also ensure that contractors are informed of this policy if it is applicable or pertinent to their scope of work. ***Implementation of this policy shall begin as soon as possible. Full implementation shall be completed by July 31, 2002.***

Policy Dissemination and Filing Instructions. Managers/supervisors of DMH and DMH contractors (if it is applicable or pertinent to the contractor's scope of work) must ensure that staff and consumers are informed of this policy. Each staff person who maintains policy manuals must promptly file this policy in Volume I of the blue **DMH** Policy and Procedures Manual and contractors must ensure that this policy is maintained in accordance with their internal procedures.

ACTION

REMOVE AND DESTROY	**INSERT**
NONE	**DMH Policy 200.2**

Martha B. Knisley
Director, DMH

NOTE: **Effective May 11, 2007, this policy and guidelines no longer apply to children & youth.** Refer to DMH Policy 200.5 for the new Child/Youth COC Guidelines. However, this policy and guidelines continue to apply to adult consumers until the new COC policy and guidelines are issued for adults.

GOVERNMENT OF THE DISTRICT OF COLUMBIA DEPARTMENT OF MENTAL HEALTH	Policy No. 200.2	Date July 25, 2002	Page 1
	Supersedes None		

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3. **Authority**. Mental Health Service Delivery Reform Act of 2001.

4. **Definitions/Abbreviations.** For purposes of this policy:

4a. Acute Care Facility – private hospitals, St. Elizabeths, and community based residential facilities at which acute or crisis mental health services are provided, referred to as "facility" in this document.

4b. Consumer – adults, children, or youth who seek or receive mental health services or mental health supports funded or regulated by DMH.

4c. Continuity of Care Practice Guidelines – guidelines that describe the responsibilities and actions of providers and DMH in response to consumers who seek or receive urgent or emergency mental health treatment and supports and/or transfer, or who are discharged to different levels of care within the mental health system.

4d. Core Services Agency (CSA) – a DMH certified community-based MHRS provider that has entered into a Human Care Agreement with DMH to provide specified MHRS. CSAs act as the clinical home for consumers of mental health services by providing a single point of access and accountability for diagnostic assessment, medication somatic treatment, counseling, community support services, and access to other needed services.

4e. Crisis Emergency Provider (CEP) – a provider certified by DMH to provide crisis emergency services and who has contracted with DMH to provide same. This provider may be part of a CSA or may be a separate entity. The provider is accessible twenty-four (24) hours per day, seven (7) days per week to offer crisis intervention to callers who are in crisis, to dispatch mobile crisis services, and to assist all persons in the District who may need emergency mental health care.

4f. Individual Plan of Care (IPC) – the individualized plan of care for children and youth, which is the result of the diagnostic/assessment service provided by the CSA. The IPC is maintained by the consumer's CSA. The IPC includes the consumer's treatment goals, strengths, challenges, objectives, and interventions. The IPC is the authorization of treatment, based on certification that the MHRS are medically necessary by the approving practitioner.

4g. Individual Recovery Plan (IRP) – the individualized recovery plan for adult consumers, which is the result of the diagnostic/assessment service provided by the CSA. The IRP is maintained by the consumer's CSA. The IRP includes the consumer's treatment goals, strengths, challenges, objectives, and interventions. The IRP is the authorization of treatment, based upon certification that MHRS are medically necessary by an approving practitioner.

4h. Mental Heath Provider– (a) any individual or entity, public or private, that is licensed or certified by the District of Columbia to provide mental health services or mental health supports, (b) any individual or entity, public or private, that has entered into an agreement with DMH to provide mental health services or mental health supports, or (c) St. Elizabeths Hospital or the D.C. Community Services Agency, referred to in this policy as "provider."

4i. Private Hospitals – those private hospitals in the District of Columbia that have arrangements with the DMH for provision of services to DMH consumers.

5. **Policy. Every consumer in the Department of Mental Health will be enrolled with a core services agency (CSA) that will provide a single point of access, accountability, and treatment planning for that consumer's needed services. To ensure continuity of care, all providers will follow the DMH established Continuity of Care Practice Guidelines, and all subsequent revisions, in the provision of services to consumers of mental health treatment in the District of Columbia.**

6. **Responsibilities for DMH**. DMH shall:

6a. **Issue** Continuity of Care Practice Guidelines with the DMH Provider Manual to all newly certified providers;

6b. **Notify** providers of all changes to the Continuity of Care Practice Guidelines as soon as the changes become effective; and

6c. **Monitor** treatment and care in compliance with the Continuity of Care Practice Guidelines and this policy, and take appropriate action where necessary.

7. **Specific Guidance for All Providers**. All providers shall:

7a. **Obtain** the Continuity of Care Practice Guidelines by contacting the DMH Mental Health Rehabilitation Services (MHRS) Project Office at 673-7440 if guidelines have not been received;

7b. **Utilize** the Continuity of Care Practice Guidelines for urgent, emergency, transfer, and admission and discharge situations when:

(1) A consumer presents for treatment at a provider who is neither a CSA nor CEP;
(2) A consumer is assigned to the provider via the Access HelpLine or is linked or referred to them from another party;
(3) A consumer presents for treatment at a crisis emergency provider;
(4) A consumer presents for treatment at a CSA;
(5) A consumer is admitted to or discharged from an acute care facility; and
(6) A consumer transfers to another CSA.

The guidelines address specific steps to follow as a consumer moves from one level of care to another, transfers from one provider to another, is admitted for acute care, or is discharged.

7c. **Adhere** to DMH clinical policies, including DMH Policy 311.1, D.C. Medication Access Project (DCMAP).

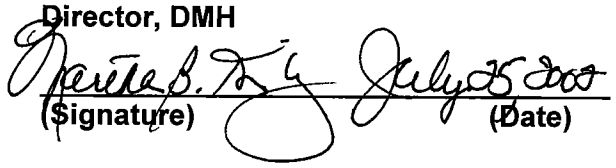
7d. **Link** the consumer to resources that are most relevant to the consumer's identified needs. The provider shall link the consumer to these services, rather than having the consumer locate their own services; and

7e. **Be Familiar** with the Continuity of Care Practice Guidelines and all subsequent revisions as they become available, and follow them as IRPs/IPCs are developed for the consumers to ensure continuity of care.

8. **References**. DMH Provider Manual

Approved By:

Martha B. Knisley
Director, DMH



(Signature) **(Date)**

NOTE: Effective May 11, 2007, these guidelines no longer apply to children and youth. Refer to DMH Policy 200.5 for the new Child/Youth COC Guidelines. However, these guidelines continue to apply to adult consumers until the new COC policy and guidelines are issued for adults.

Department of Mental Health
Continuity of Care Practice Guidelines for
Participants in the Mental Health System of Care

These guidelines outline the responsibilities of the District of Columbia Department of Mental Health (hereafter called DMH) system of care participants who are as follows: DMH Mental Health Authority, community providers, and hospital providers of care for DMH funded mental health services and supports throughout the D.C. DMH system of care.

The following describes the responsibilities and actions of providers and DMH Division of Care Coordination Access Helpline in response to consumers who seek or receive urgent or emergency mental health treatment and supports and/or transfer to different levels of care within the mental health system. Access procedures for routine needs will be addressed in DMH Policy 200.1, Access to Mental Health Services and Supports.

The provider shall adhere to DMH clinical policies, including D.C. Medication Access Project (DCMAP), DMH Policy 311.1

1. Crisis Response, Urgent and Emergency Care.

Consumers in crisis (whether meeting Mental Health Rehabilitation Services (MHRS) urgent or emergency need standards) may first seek or be presented for treatment at several different locations. There are providers who have multiple roles in the system of care. The provider's crisis response shall be consistent with the provider's role for that consumer, based on that consumer's need at that time.

DMH performs community outreach and education to those who contact the DMH Access Helpline for dispatch of MHRS crisis emergency providers or linkage to core services agency (CSA) on-call or urgent services. All providers are expected to comply with federal and District law for emergency stabilization prior to accessing authorizations or taking other treatment actions.

1A. Presentation at Providers who are neither Core Services Agencies (CSAs) nor Crisis Emergency Providers (CEP):

When a consumer presents or is presented at a provider that is not certified as a CSA or a CEP, the provider shall either call 911 or provide any needed emergency care to stabilize immediate life threatening situations as applicable, and then refer consumers based on that provider's knowledge of that consumer's status.

1. Providers will direct consumers who are NOT enrolled with a CSA to the DMH Access HelpLine or a CEP per consumer choice.

    - The DMH Access HelpLine will be notified by telephone call of any consumers directed to CEP.

2. Providers will link consumers who are enrolled to their CSA.

1B. Contacting the DMH Access HelpLine:

When a consumer or family member contacts the DMH Access HelpLine or contact is made by another individual or entity, the DMH Access HelpLine staff will complete the Crisis Assessment Event in eCura, with appropriate Risk & Resiliency screening.

1. When the consumer's needs are identified as urgent or emergency (based on the Risk & Resiliency score):

    a. If consumer has a CSA, contact the CSA utilizing the Unscheduled Access policy for that CSA, unless immediately calling 911 is indicated upon determination that the consumer is in imminent danger to self or others, or a referral to CEP is needed.

        i. if no response from CSA within thirty (30) minutes, page CSA again.

        ii. if no response from CSA within two (2) hours from first contact, contact the CSA senior administrator or designee.

    b. If consumer does not have a CSA, contact a CEP first by consumer's choice, second by location (closest to the consumer), and third by availability, unless immediately calling 911 is indicated upon determination that the consumer is in imminent danger to self or others.

    c. Document linkage to services and outcome (e.g., inform the consumer that the CEP mobile team practitioner will visit consumer, and/or that the individual in need may go directly to a CEP).

1C. Presentation at Providers who are CEP:

When a consumer is treated at any CEP (Crisis/Emergency Provider) whether that consumer presents directly or by linkage from Access HelpLine or elsewhere, the following must be done before any disposition or outcome:

1. All consumers regardless of access need or treatment status, must be evaluated for the least restrictive, most integrated setting for services to occur. This will include explanation of the full array of DMH services and supports, as well as the availability of in-home crisis emergency MHRS provided in the consumer's natural setting.

    a. If consumer has a CSA, page CSA for all urgent or emergency scores, unless immediately calling 911 is indicated upon determination that the consumer is in imminent danger to self or others:

        i. If no response within one (1) hour, page CSA again.

ii. If no response within two (2) hours, CEP should notify the Access HelpLine for follow up with CSA.

iii. CEP should provide services, and may call the Access HelpLine for override of the authorization plan if CSA has not responded, and follow subsections 2, 3, and 4 below as applicable.

b. If consumer has no CSA:

- File the interim or crisis authorization plan for treatment and linkage to services in the eCura Provider Connect, and follow subsections 2, 3, and 4 below as applicable.

2. All consumers regardless of access need or treatment status, must have an authorization plan submitted to DMH Division of Care Coordination Access Helpline that includes the following criteria:

   a. Crisis stabilization;

   b. Support identification, and significant other involvement whenever possible;

   c. If a D.C. resident or homeless in D.C., linkage to private mental health provider or CSA;

   d. If not a D.C. resident, referral to the consumer's home jurisdiction, which shall be documented by at least one (1) telephone contact with mental health authority representatives in the home jurisdiction; and

   e. Outcome goals for crisis emergency services that include follow up to ensure linkage and ongoing supports.

3. Consumers who meet criteria for emergency need or have a FD-12, Application for Emergency Hospitalization, for involuntary treatment assessment must be seen within one (1) hour. This contact with the consumer must include a full evaluation including mental status examination, screening for suicide or homicidal ideation, medical screening, and assessment of need for hospitalization. This contact with the consumer will be required for admission to a facility. Admission to a DMH acute care facility may proceed if a treating physician recommends admission and the one (1) hour response time has passed for CEP to arrive.

4. Consumers who meet criteria for urgent need for mental health services must be seen within twenty-four (24) hours, and should have a full evaluation including mental status examination, screening for suicide or homicidal ideation, and medical screening. The CEP will complete a crisis authorization plan that authorizes MHRS to ensure linkage to a CSA and ongoing services and support.

1D. Presentation at Providers who are CSA:

When a consumer presents in crisis at a CSA:

1. Provide any needed emergency care to stabilize immediate life threatening situations, which may include but is not limited to calling 911, and then refer consumers based on that provider's knowledge of that consumer's status.

2. Use the MHRS Provider Manual and these practice guidelines and/or Risk & Resiliency screening to indicate level of acuity and appropriate service needs.

3. If an enrolled consumer in active treatment meets the guidelines for urgent or emergency need, appropriate clinical intervention must be initiated within the two (2) hour response time:

   a. CSA on-call staff will have access to Individual Recovery Plan (IRP)/Individual Plan of Care (IPC) crisis plans, and consult these plans in on-call responses;

   b. Intervention will include a workable, behavior based plan for resolving the crisis including steps, outcomes, timeframes, and indication of when the next level of response should be initiated; and

   c. Interventions shall be used to create or update the IRP/IPC, and/or the crisis plan.

4. If the consumer is not in active treatment with that CSA, the CSA may refer to a CEP.

2. Continuity of Care Upon Admission to an Acute Care Facility.

It is the responsibility of the provider recommending admission to determine if the consumer is enrolled in a CSA. The Access HelpLine will be contacted for pre-authorization of admission. Upon the admission to an acute care facility (referred to as facility) the protocol below will be followed.

2A. If the Consumer has a CSA:

1. The provider recommending admission will communicate with the consumer's CSA within one (1) business day of admission.

   - This means that if the recommending doctor is with a crisis/emergency provider, they must communicate with the consumer's CSA doctor. If the recommending doctor is the consumer's CSA on-call doctor, they have an affirmative responsibility to communicate with the consumer's attending doctor (and the consumer's approving practitioner if this person is different).

2. Communication from the recommending provider to the facility practitioner must include review of treatment course, medication history, and review of the treatment plan.

3. The CSA clinical manager or approving practitioner for that consumer's IRP/IPC will have face to face contact with the consumer and designated facility staff within two (2) business days of admission.

   - Communication with designated facility staff will include the consumer's psychosocial history, IRP/IPC, treatment history, and scheduling of initial treatment team meeting with facility staff.

4. If the consumer is transferred from one facility to another (for example St. Elizabeths or another acute hospital from crisis beds), the clinical manager or clinician designated in the consumer's IRP/IPC from the CSA will communicate with the new facility's designated staff within one (1) business day after transfer.

5. The CSA clinical manager or approving practitioner for that consumer's IRP/IPC will have face to face contact with the consumer and the new facility staff within two (2) business days after transfer.

   - Communication with facility staff will include the consumer's psychosocial history, IRP/IPC, treatment history, and scheduling of initial treatment team meeting with new facility's staff.

6. During the time of treatment in the facility, the clinical manager from the CSA, or clinician designated in the consumer's IRP/IPC, shall:

   a. Have face to face contact with consumer twice a week for the first thirty (30) days of stay at the facility;

   b. Have face to face contact with the consumer once a week for subsequent lengths of stay at the facility;

   c. Make contact with significant others as noted on the IRP/IPC and in the advanced instructions to notify of admission the same day if possible, and no later than the following day or as directed in the consumer's IRP/IPC advanced instructions;

   d. Make contact with the facility treatment team at an initial treatment planning meeting within five (5) calendar days of admission to the facility, this treatment planning meeting must include establishing discharge planning with the consumer and facility treatment team;

e. Make contact with the facility treatment team weekly thereafter, this may include attendance at treatment planning meetings; and

f. Ensure attendance by at least one (1) member of the CSA treatment team at the facility's treatment planning meetings for that consumer.

7. The CSA clinical manager or clinician designated in the consumer's IRP/IPC, will develop discharge planning with the consumer and facility staff which address individual community service and support needs, including benefits acquisition, and housing resources, as documented in the IRP/IPC.

8. CSA staff will maintain progress notes in the facility's clinical records and at the CSA, reflecting all meetings and communications with facility staff, the consumer, and all significant others. If necessary the CSA treating psychiatrist will consult telephonically or in person with the facility treating psychiatrist.

9. Discharge planning and documentation must include:

   a. A scheduled medication somatic appointment for all consumers on psychotropic medications with the CSA within ten (10) business days of discharge;

   b. A face to face meeting between the clinical manager, or clinician designated in the consumer's IRP/IPC and the consumer within one (1) business day of the consumer's discharge from facility to the community; and

   c. Evidence of an attempt to address the consumer's individual needs including benefits acquisition, and housing, as applicable.

2B. If Consumer has no CSA:

1. Recommending provider (CEP provider staff) or facility staff will notify the DMH Access HelpLine of the admission and the lack of an assigned CSA.

2. The DMH Access HelpLine staff will enroll consumer with a CSA. If the consumer is able and willing to have a telephone conversation this will be done through the consumer choice process. If the consumer is unable or unwilling to have this telephone contact, a CSA will be assigned to this consumer, first by home location, then by location of consumer at time of crisis.

   a. If CSA assignment occurs:

      i. The facility will be faxed a copy of the CSA choice menu form for completion when consumer is more stable; and

      ii. The facility staff will be responsible for ensuring that this form is completed.

3. The DMH Access HelpLine will notify assigned CSA of admission of consumer and their enrollment to CSA within twenty-four (24) hours so that the CSA can begin the discharge planning process from the facility.

4. The CSA clinical manager will make face-to-face contact with the consumer within two (2) business days of the consumer being assigned to that CSA.

5. A designated facility staff member will educate the consumer as to CSA choices and will ensure that the choice menu form is completed and filed in the clinical record. The designated facility staff member will give the consumer their status regarding CSA assignment. A copy of this signed choice menu form will be provided to the new CSA by the facility staff member by the time the discharge occurs.

6. The new CSA becomes responsible for fulfilling the responsibilities as stated in Section 2, Continuity of Care Upon Admission to an Acute Care Facility, 2A, 3-9 above.

2C. Responsibilities of the Acute Care Facility:

During every admission to a DMH funded or regulated facility, the facility will perform the following responsibilities for the consumer's continuity of care. Acute care facilities have additional responsibilities, such as those imposed by District and federal laws including the Ervin Act.

1. Schedule an initial treatment planning meeting within seventy-two (72) hours of admission and document invitation of a CSA representative;

2. Ensure the consumer's attendance at all appropriate treatment planning meetings, and every discharge planning meeting;

   a. In situations where the consumer does not demonstrate capacity to attend such meetings, or does not wish to attend, the facility shall record the reason the consumer did not attend in the clinical record; and

   b. Document each time an attempt was made to include the consumer for every date where a consumer did not attend.

3. Notify the CSA immediately of any transfer or unplanned discharge; and

4. At discharge, the facility will provide enough medication for the consumer until the next scheduled medication somatic appointment scheduled at their CSA, or as determined in the discharge planning process.

3. Continuity of Care For any CSA Transfer/Change.

Consumers have the right to change their current CSA at any time for any reason or for no reason. This change can be made by telephone call only to the DMH Access HelpLine. Access HelpLine staff will close the enrollment with the transferring CSA and open enrollment with the enrolling CSA. A consumer's change of CSA will be effective at midnight of the following day from the date of their change request call to the DMH Access HelpLine. Three (3) changes of CSA by a consumer within a benefit year will trigger a Care Coordination utilization review.

3A. Responsibilities upon Knowledge of Consumer's Intent to Transfer/Change CSA:

1. When a consumer notifies the CSA clinical manager/approving practitioner of his/her decision to change CSA, the CSA clinical manager/approving practitioner will:

   a. Educate the consumer as to all available CSA's and their services, but may neither recommend nor suggest a CSA; and

   b. Assist the consumer, if he/she so desires with visiting the other CSA's and meeting with a representative from each CSA.

2. When the consumer makes a choice as to the enrolling CSA he/she wants to receive services from, the CSA clinical manager/approving practitioner will:

   a. Contact the enrolling CSA to notify it of consumer's decision to transfer;

   b. Assist consumer with contacting the DMH Access Helpline to arrange for transfer;

   c. After obtaining a completed and signed authorization for disclosure form from the consumer, meet face to face with the enrolling CSA clinical manager/approving practitioner within one (1) week of the transfer to the enrolling CSA;

      - If the consumer agrees, he/she will also attend this meeting so that the transferring clinical manager/approving practitioner can introduce him/her to the enrolling clinical manager/approving practitioner.

   d. Obtain a completed and signed authorization for disclosure form from the consumer that meets requirements of the Mental Health Information Act of 1978, D.C. Official Code §7-1201.01, *et seq.*, and then send the following documentation to the enrolling CSA within one (1) week of the transfer:

      i. Clinical assessments;

      ii. IRP/IPC;

iii. Clinical manager/approving practitioner case notes for past six (6) months;

iv. Psychiatrist case notes for past six (6) months; and

v. Current medication records including lab reports.

e. If the consumer refuses to sign an authorization for disclosure form for sharing records, the enrolling CSA clinical manager/approving practitioner will discuss with the consumer the importance of the sharing of information and present options to the consumer for a limited authorization of disclosure. This may mean educating the consumer as to what portions of the record would be acceptable to transfer to the enrolling CSA.

3. If the consumer transfers to an enrolling CSA without first notifying the transferring CSA, both agencies will learn of this via the eCura system. When this occurs, the discharged CSA will:

a. Obtain a completed and signed authorization for disclosure form from the consumer and send the following documentation to the enrolling CSA within one (1) week of the transfer:

i. Clinical assessments;

ii. IRP/IPC;

iii. Clinical manager/approving practitioner case notes for past six (6) months;

iv. Psychiatrist case notes for past six (6) months; and

v. Current medication records including lab reports.

b. After obtaining a completed and signed authorization for disclosure form, meet face to face with the enrolling CSA clinical manager/approving practitioner within one (1) week of the transfer to the enrolling CSA.

c. If the consumer agrees, he/she will also attend this meeting so that the transferring clinical manager/approving practitioner can introduce him/her to the enrolling clinical manager/approving practitioner.

4. If the consumer refuses to sign an authorization for disclosure form for sharing records, the enrolling CSA clinical manager/approving practitioner will discuss with the consumer the importance of the sharing of information and present options to the consumer for a limited authorization of disclosure. This may mean educating the consumer as to what portions of the record would be acceptable to transfer to the enrolling CSA.

4. Monitoring.

The DMH will monitor compliance with the Continuity of Care Practice Guidelines including provider responsiveness when paged or called regarding a crisis/emergency situation. Appropriate action will be taken as necessary.

5. Related References.

DMH Policy 200.2, Continuity of Care

6. Definitions. For purposes of these guidelines:

a. Acute Care Facility – private hospitals, St. Elizabeths, and community based residential facilities at which acute or crisis mental health services are provided, referred to as "facility" in this document.

b. Approving Practitioner – the qualified practitioner responsible for overseeing the development of and approval of the IRP or IPC. The approving practitioner serves on the diagnostic/assessment team and may also serve as the clinical manager.

c. Authorization Plan – items from the ISSP and the IRP/IPC that are entered into eCura and Provider Connect and result in authorization plan numbers.

d. Clinical Manager – the qualified practitioner chosen by the consumer to coordinate service delivery. The clinical manager shall participate in the development and review of the consumer's IRP/IPC, along with the approving practitioner. The clinical manager may also serve as the approving practitioner. The clinical manager shall be employed by the CSA, except that a psychiatrist serving as a clinical manager may be under contract to the CSA.

e. Consumer – adults, children, or youth who seek or receive mental health services or mental health supports funded or regulated by the DMH.

f. Core Services Agency (CSA) – a DMH certified community-based MHRS provider that has entered into a Human Care Agreement with DMH to provide specified MHRS. CSAs act as the clinical home for consumers of mental health services by providing a single point of access and accountability for diagnostic assessment, medication somatic treatment, counseling, community support services, and access to other needed services.

g. Crisis Emergency Provider (CEP) - A provider certified by DMH to provide crisis emergency services and who has contracted with DMH to provide same. This provider may be part of a CSA or may be a separate entity. The provider is accessible twenty-four (24) hours per day, seven (7) days per week to offer crisis intervention to callers who are in crisis, to dispatch mobile crisis services, and to assist all persons in the District who may need emergency mental health care.

h. DMH Access Helpline – a telephone-based service center operated by DMH twenty-four (24) hours per day, seven (7) days per week. The DMH Access Helpline, 888-7WE-HELP (888-793-4357), provides crisis intervention, information and referral, service authorization and eligibility and enrollment to the DMH system of care.

i. Emergency Need – for consumers who are involved in active crisis where the safety of the consumer or others is at risk within the next twenty-four (24) hours. Safety may be at risk due to suicide, homicide, and/or severe decompensation of functioning. CSAs response is required within two (2) hours of a request. Crisis emergency services by a CEP must be provided within one (1) hour of the request or referral.

j. Individual Plan of Care (IPC) - the individualized plan of care for children and youth, which is the result of the diagnostic/assessment service provided by the CSA. The IPC is maintained by the consumer's CSA. The IPC includes the consumer's treatment goals, strengths, challenges, objectives, and interventions. The IPC is the authorization of treatment, based on certification that the MHRS are medically necessary by the approving practitioner.

k. Individual Recovery Plan (IRP) - the individualized recovery plan for adult consumers, which is the result of the diagnostic/assessment service provided by the CSA. The IRP is maintained by the consumer's CSA. The IRP includes the consumer's treatment goals, strengths, challenges, objectives, and interventions. The IRP is the authorization of treatment, based upon certification that MHRS are medically necessary by an approving practitioner.

l. Mental Heath Provider– (a) any individual or entity, public or private, that is licensed or certified by the District of Columbia to provide mental health services or mental health supports, (b) any individual or entity, public or private, that has entered into an agreement with DMH to provide mental health services or mental health supports, or (c) St. Elizabeths Hospital or the D.C. Community Services Agency, referred to in these guidelines as "provider."

m. Mental Health Rehabilitation Services (MHRS) – those mental health services performed by DMH certified providers, according to the Mental Health Rehabilitation Services Provider Certification Standards; Chapter 34 of Title 22 District of Columbia Municipal Regulations.

n. Natural Settings – the consumer's residence, workplace, or other locations in the community the consumer frequents, such as the consumer's home, school, workplace, community centers, homeless shelters, street locations, or other public facilities. Natural settings do not include inpatient hospitals or community residential facilities.

o. Routine Need – CSAs response time of seven (7) business days for individuals seeking services who are not in urgent or emergency need.

p. System of Care for Adults – means a community support system for persons with mental illness that is developed through collaboration in the administration, financing, resource allocation, training, and delivery of services across all appropriate public systems. Each person's mental health services and mental health supports are based on an individual recovery plan (IRP), designed to promote recovery and develop social, community and personal living skills, and to meet essential human needs. It includes the appropriate integrated, community-based outpatient services and inpatient care, outreach, emergency services, crisis intervention and stabilization, age-appropriate education and vocational readiness and support, housing and residential treatment and support services, family and caregiver supports and education, and services to meet special needs, which may be delivered by both public and private entities.

q. System of Care for Children, Youth, and their Families – means a community support system for children or youth with mental health problems and their families, which is developed through collaboration in the administration, financing, resource allocation, training, and delivery of services across all appropriate public systems. Each child's or youth's mental health services and mental health supports are based on a single, child-and youth-centered, and family-focused individual plan of care (IPC), encompassing all necessary and appropriate services and supports, which may be delivered by both public and private entities. Prevention, early intervention, and mental health services and mental health supports to meet individual and special needs are delivered in natural, nurturing, and integrated environments, recognize the importance of a support for the maintenance of enduring family relationships, and are planned and developed within the District and as close to the child's or youth's home as possible so that families need not relinquish custody to secure treatment for their children and youth.

r. Urgent Need – CSAs response time of twenty-four (24) hours for consumers experiencing distress that will develop into a crisis state without intervention, but where there is not yet imminent threat of harm to the consumer or others. Distress may be defined as at risk behavior such as suicide, homicide, a recent major loss, or a severe decompensation of functioning. Services must be provided within the same day of consumer presentation.

Approved By:

Martha B. Knisley
Director, DMH

Martha Knisley July 15 2002

(Signature) **(Date)**